CHIP
Children's Health Insurance Program

CO-PAY SUMMARY

Molina: 1-800-483-0760 • www.health.utah.gov/chip • PEHP: 1-800-765-7347

BENEFITS (per plan year)	CO-PAY PLAN A*	CO-PAY PLAN B*	CO-PAY PLAN C*
OUT-OF-POCKET MAXIMUM	5% of family's annual gross income	5% of family's annual gross income	5% of family's annual gross income
PREMIUM	$0	$30/family/quarter	$60/family/quarter
PRE-EXISTING CONDITION	No waiting period	No waiting period	No waiting period
DEDUCTIBLE	None	None	$250/person; $500/family for inpatient, outpatient hospital and major diagnostic services
WELL-CHILD EXAMS	$0	$0	$0
IMMUNIZATIONS	$0	$0	$0
DOCTOR VISITS	$3	$5	$20
SPECIALIST VISITS	$3	$5	$25
EMERGENCY ROOM	$3	$5	$75
AMBULANCE	$3	5% of total	20% of total
URGENT CARE CENTER	$3	$5	$25
AMBULATORY SURGICAL & OUTPATIENT HOSPITAL	$3	5% of total	10% after deductible
INPATIENT HOSPITAL SERVICES**	$25	$100	10% after deductible
LAB AND X-RAY	$3 for x-ray/lab tests over $350	$0 for x-ray/lab tests under $350; 5% of total for each test over $350	$0 for x-ray/lab test under $350; 20% of total for each test over $350, after deductible
SURGEON	$0	$0	$0
ANESTHESIOLOGIST	$0	$0	$0
PRESCRIPTIONS **- Preferred Generic Drugs** **- Preferred Brand Name Drugs** **- Non-Preferred Drugs**	GENERIC - $1 for drug under $50; $3 for drug over $50 BRAND NAME - $1 for drug under $50; $3 for drug over $50 NON-PREFERRED - 5%	GENERIC - $5 BRAND NAME - $5 NON-PREFERRED - 5% of total	GENERIC - $10 BRAND NAME - 25% of discounted cost up to a 30-day supply, $5 min. NON-PREFERRED - 50% of discounted cost up to a 30-day supply, $5 min.
DENTAL **- Exams, Fluoride, etc.** **- Selected Fillings, Crowns, etc.**	 - $0 - $3	 - $0 - $5	 - $0 - 20% of total
MENTAL HEALTH** **- Inpatient Hospital** **- Outpatient Visit**	 - $25 (20 day limit) - $3 (20 visit limit)	 - $100 (20 day limit) - 5% of total (20 visit limit)	 - 30% after deductible (20 day limit) - 30% of total (20 visit limit)
PHYSICAL THERAPY	$3 (20 visit limit)	$5 (20 visit limit)	$25 (20 visit limit)
CHIROPRACTIC VISITS	$3 (8 visit limit)	$5 (8 visit limit)	$25 (8 visit limit)
HOME HEALTH AND HOSPICE CARE**	$3	5% of total	10% of total
MEDICAL EQUIPMENT & MEDICAL SUPPLIES**	$3	5% of total	20% of total
DIABETES EDUCATION	$0	$0	$0
VISION SCREENING	$3 (limit 1)	$5 (limit 1)	$20 (limit 1)
HEARING SCREENING	$3 (limit 1)	$5 (limit 1)	$20 (limit 1)

* Co-pay plans are based on your income. American Indian/Alaska Natives will not be charged co-payments, premiums, or a deductible.

** Requires prior authorization or pre-notification